# *Heuer House Referral Form*

Date of Referral: _____ Anticipated Admission Date: _____

Name: _____

DOB: _____ Age: _____ Home Phone: _____

Social Security: _____ MA#: _____

Gender: ____Male ___Female

Ethnicity: _____ Caucasian ____ African American ___ Asian ___ Hispanic/Latino

Marital Status: ___Single ___Married ___Divorce ___Separated

Are you United States Veteran? ___Yes ___No

Present Living Arrangement: _____Homeless _____Incarceration ____Living with others

***INCOME***

Source of Income: _____ Monthly Amount: _____

***REFERRAL SOURCE***

Agency: _____

Contact Person: _____

Address: _____

Phone: _____ Ext_____ Fax: _____

***TREATMENT HISTORY***

DESCRIPTION OF SUBSTANCE ABUSE/MENTAL HEALTH DIAGNOSIS:

_____

_____

_____

***Level of Care Assessment Completed: ___ Yes ___ No***

_____

***LOC Agency Name & Date Completed***

_____

**Signature & Date**